STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155271	A. BUILDING 00 B. WING	03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S SENIOR LIVING COMMUNITY	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00104878. Complaint IN00104878: Unsubstantiated due to lack of evidence. Survey dates: March 26, 27, 28, 29, and 30, 2012 Facility number: 000171 Provider number: 155271 AIM number: 100267050 Survey team: Janet Stanton, R.N.--Team Coordinator Heather Lay, R.N. (3/26, 27, 28, 29) Melanie Strycker, R.N. Census bed type: SNF--14 SNF/NF--52 Total--66 Census payor type: Medicare--15 Medicaid--46 Other--5 Total--66 Sample: 15	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on April 4, 2012 by Bev Faulkner, R.N.			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to suspend a C.N.A. from	F0225	Miller's Senior Living is requesting paper compliance with regards to the plan of correction submitted	04/22/2012

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	work following an allegation of verbal abuse. The deficient practice had the potential to impact 2 of 2 residents who were named in 1 of 3 facility investigations which were reviewed for alleged abuse violations. [Resident #71 and #72; C.N.A. #2] Findings include: 1. During the pre-survey meeting on 3/26/12, incidents reported to ISDH since the last annual survey were reviewed. At the entrance conference on 3/26/12 at 10:15 A.M., the Executive Director was given the opportunity to submit the investigation documentation for three of the incidents that reported allegations of abuse. On 3/26/12 at 3:00 P.M., the Executive Director provided the investigation documentation for an incident reporting alleged verbal abuse, and involving Residents #71 and #72. The "Unusual Occurrence/Incident Report Form" included, but was not limited to, the following: "Incident Date: 12/16/11... Residents Involved: [Resident #71 and #72]... Brief Description of Incident: On 12/15/11 at 10:45 A.M., the daughter of a		below. F225 Investigation/ Report Allegations/ Individuals – Miller's Senior Living respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefix F225. 1.The resident cited in the deficiency no longer reside with in the facility. 2.The facility reviewed all allegation of abuse that occurred the past 12 months to ensure no other residents were affected by the deficient practice. There were no other instances of this deficient practice. 3.The "Abuse Prohibition, Reporting and Investigation" policy will be reviewed by all staff. A focus will be placed on understanding that per the Resident Abuse section of the "Abuse Prohibition, Reporting and Investigation" policy it is required that and staff implicated in an allegation of abuse will be removed from the facility (not just removed from the resident care area) and suspended until the investigation is completed. 4.To ensure the deficient practice does not recur, the Abuse QA tool (attachment A) will be completed at the time of the investigation. (The reason for the prompt completion of an audit tool is related to the fact that this is an abuse policy.) This tool will be completed by the Corporate Regional Vice President or his	

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	resident came to social service office to report a verbal incident overheard last night (12/14) between staff member [C.N.A. #2] and patient [Resident #71 or Resident #72] across the hall from her mother. Per the daughter, she overheard staff member [C.N.A. #2] state to patient [Resident #71 or #72], "I don't want to pick you up from the floor, so you better move your ass..." Immediate Action Taken: The C.N.A. [C.N.A. #2]... who was pointed out by the family was working at the time the incident was reported... She [C.N.A. #2] was removed from the floor immediately and an investigation was initiated... The C.N.A. was interviewed and statements were taken. The residents who were across the hall or in close proximity were interviewed as part of the investigation. This comment could not be confirmed. Residents had no incidents to report of inappropriate behavior or language. The residents were happy with their care and the care provided by this individual. Further investigation showed that the daughter does not think this was threatening in any way, but felt it was an inappropriate statement between staff and resident." A document titled "Investigation for Allegation of Abuse on 12/15/11" included, but was not limited to, the		designee in conjunction with the Administrator at the time of the investigation. 5.The facility will have all inservicing completed and auditing in place by April 22, 2012.	

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	following: "Director of Nursing [DoN] and Administrator spoke with [Resident #71] this morning. When resident asked in general about her stay here and staff that have worked with her, resident [Resident #71] reported that everyone has been very nice. When asked specifically about the evening of 12/14/11, resident [Resident #71] reported the evening went fine... DoN and Administrator spoke with [Resident #72] this morning. When asked about the staff that have cared for her here, she reported everyone has been nice. She stated she enjoyed joking with the staff and has never heard anyone speak inappropriately or use inappropriate language... She [Resident #72] reports she was assisted by C.N.A. #2, who has always been nice to her...." An "Abuse Investigation Worksheet," dated 12/15/11, indicated "No actual allegation. Just investigation to see if allegation... Interview with other residents and/or physical assessment conducted: Not needed; Interview with staff member conducted: Not needed... Reported because investigation done. Never was allegation." In an interview on 3/27/12 at 10:15 A.M., the Executive Director indicated C.N.A. #2 was placed in the Executive Director's office while interviews were being done			

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	with Residents #71 and #72. The C.N.A. was not suspended at that time, and returned to her assignment the same day after the initial interviews with Resident #71 and #72. The Executive Director indicated they did not believe that any verbal abuse had occurred, based on the interviews with Resident #71 and #72 and a further interview with the family member who had reported the incident. She indicated the facility reported the incident because an investigation had been done only to determine if there was an allegation of verbal abuse. 2. The facility "Abuse Prohibition, Reporting, and Investigation Policy and Procedure" dated 1/14/12 was received on 3/26/12 at 11:00 A.M. The policy and procedure included, but was not limited to: "DEFINITIONS: ... 4. Verbal Abuse--is defined as the use of oral, written and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing, regardless of their age, ability to comprehend, or disability...." 3.1-28(d)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed, related to the failure to suspend an employee from work during the alleged violation of abuse investigation, for 1 of 3 abuse allegations reviewed. The deficient practice had the potential to affect 2 of 2 residents [Resident #71 and #72] reviewed for alleged abuse violations from a sample of 15. Findings include: 1. During the pre-survey meeting on 3/26/12, incidents reported to ISDH since the last annual survey were reviewed. At the entrance conference on 3/26/12 at 10:15 A.M., the Executive Director was given the opportunity to submit the investigation documentation for three of the incidents that reported allegations of abuse. On 3/26/12 at 3:00 P.M., the Executive Director provided the investigation documentation for an incident reporting	F0226	Miller's Senior Living is requesting paper compliance with regards to the plan of correction submitted below. F226 Investigation/ Report Allegations/ Individuals – Miller's Senior Living respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefix F226. 1.The resident cited in the deficiency no longer reside with in the facility. 2.The facility reviewed all allegation of abuse that occurred the past 12 months to ensure no other residents were affected by the deficient practice. There were no other instances of this deficient practice. 3.The "Abuse Prohibition, Reporting and Investigation" policy will be reviewed by all staff. A focus will be placed on understanding that per the Resident Abuse section of the "Abuse Prohibition, Reporting and Investigation" policy it is required that and staff implicated in an allegation of abuse will be removed from the facility (not just removed from the resident care area) and suspended until the	04/22/2012

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	alleged verbal abuse, and involving Residents #71 and #72. The "Unusual Occurrence/Incident Report Form" included, but was not limited to, the following: "Incident Date: 12/16/11... Residents Involved: [Resident #71 and #72]... Brief Description of Incident: On 12/15/11 at 10:45 A.M., the daughter of a resident came to social service office to report a verbal incident overheard last night (12/14) between staff member [C.N.A. #2] and patient [Resident #71 or Resident #72] across the hall from her mother. Per the daughter, she overheard staff member [C.N.A. #2] state to patient [Resident #71 or #72], "I don't want to pick you up from the floor, so you better move your ass..." Immediate Action Taken: The C.N.A. [C.N.A. #2]... who was pointed out by the family was working at the time the incident was reported... She [C.N.A. #2] was removed from the floor immediately and an investigation was initiated... The C.N.A. was interviewed and statements were taken. The residents who were across the hall or in close proximity were interviewed as part of the investigation. This comment could not be confirmed. Residents had no incidents to report of inappropriate behavior or language. The		investigation is completed. 4.To ensure the deficient practice does not recur, the Abuse QA tool (attachment A) will be completed at the time of the investigation. (The reason for the prompt completion of an audit tool is related to the fact that this is an abuse policy.) This tool will be completed by the Corporate Regional Vice President or his designee in conjunction with the Administrator at the time of the investigation. 5.The facility will have all inservicing completed and auditing in place by April 22, 2012.	

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	residents were happy with their care and the care provided by this individual. Further investigation showed that the daughter does not think this was threatening in any way, but felt it was an inappropriate statement between staff and resident." A document titled "Investigation for Allegation of Abuse on 12/15/11" included, but was not limited to, the following: "Director of Nursing [DoN] and Administrator spoke with [Resident #71] this morning. When resident asked in general about her stay here and staff that have worked with her, resident [Resident #71] reported that everyone has been very nice. When asked specifically about the evening of 12/14/11, resident [Resident #71] reported the evening went fine... DoN and Administrator spoke with [Resident #72] this morning. When asked about the staff that have cared for her here, she reported everyone has been nice. She stated she enjoyed joking with the staff and has never heard anyone speak inappropriately or use inappropriate language... She [Resident #72] reports she was assisted by C.N.A. #2, who has always been nice to her...." An "Abuse Investigation Worksheet," dated 12/15/11, indicated "No actual allegation. Just investigation to see if			

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	allegation... Interview with other residents and/or physical assessment conducted: Not needed; Interview with staff member conducted: Not needed... Reported because investigation done. Never was allegation." In an interview on 3/27/12 at 10:15 A.M., the Executive Director indicated C.N.A. #2 was placed in the Executive Director's office while interviews were being done with Residents #71 and #72. The C.N.A. was not suspended at that time, and returned to her assignment the same day after the initial interviews with Resident #71 and #72. The Executive Director indicated they did not believe that any verbal abuse had occurred, based on the interviews with Resident #71 and #72 and a further interview with the family member who had reported the incident. She indicated the facility reported the incident because an investigation had been done only to determine if there was an allegation of verbal abuse. 2. The facility "Abuse Prohibition, Reporting, and Investigation Policy and Procedure," dated 1/14/12, was received on 3/26/12 at 11:00 A.M. The policy and procedure included, but was not limited to: "Resident Abuse Procedure: The charge			

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	nurse is responsible to immediately notify the administrator and Director of Nurses of the situation... Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until the investigation is completed..." 3.1-28(a)			

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F0253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview and record review, the facility failed to ensure the proper cleanliness of a wheelchair foot board for 1 of 1 residents who utilized this positioning device, in a sample of 15 residents reviewed. [Resident #63] Findings include: On 3/26/12 at 2:00 P.M., environmental tour was initiated with the Executive Director, Maintenance Director, and the Regional Housekeeping Manager in attendance. On 3/26/12 at 2:40 P.M., a foot board cushion, positioned on the wheelchair pedals, was observed to have brown, smeared stained areas. At that time, the Maintenance Director indicated the wheelchair belonged to Resident #63. In an interview on 3/26/12 at 2:45 P.M., L.P.N. #3 indicated the soiled areas on the foot board were from the resident's toe, which had some drainage.	F0253	Miller's Senior Living is requesting paper compliance with regards to the plan of correction submitted below. F253 Housekeeping and Maintenance Services – Miller's Senior Living respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefix F253. 1.Resident # 63 had his foot board replaced with a material that will continue to provide padding but that has a surface that can be wiped and sanitized should it be come soiled. 2.All residents with positioning devices have had their devices inspected to ensure they are not soiled. 3.All staff will be educated on the importance of immediately replacing or cleaning any positioning devices that become soiled. 4.To ensure the deficient practice does not recur, an audit tool titled Positional Devices was put into place (attachment B). This audit tool will be completed by the DON or designee daily for 30 days then weekly for 4 weeks, and monthly thereafter. It will be reviewed by the QA team at that time to determine the need to continue. 5.The facility will have all inservicing completed and auditing in place by April 22, 2012.	04/22/2012

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	The clinical record for Resident #63 was reviewed on 3/29/12 at 12:45 P.M. Diagnoses included, but were not limited to, Parkinson's disease, diabetes, cerebral vascular accident [stroke], right hand contracture, left foot drop, and senile dementia--Alzheimer's type. The resident was admitted to an acute hospital on 3/5 and 3/17/12, with returns to the facility on 3/10 and 3/20/12 for respiratory and blood sugar issues. An electronic record progress note, dated 3/20/12, indicated "Cleanse open area left great toe--leave open to air." On 3/23/12, the physician changed the treatment order to "Start Santyl [a topical debriding enzyme]." 3.1-19(f)(5)			

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MILLER'S SENIOR LIVING COMMUNITY	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to date open liquids in 1 of 2 refrigerators, failed to date scooped ice cream in 1 of 1 freezer, failed to ensure proper concentration of Quaternary [chemical disinfectant] solution in 1 of 3 buckets of solution, and failed to prepare food away from cleaning solution in 1 of 1 preparation areas. The deficient practice impacted 1 of 1 facility kitchen and had the potential to affect 66 of 66 residents of the facility who consume food from the kitchen. Findings include: 1. On 3/26/12 at 10:20 A.M., the tour of the kitchen was initiated with the Dietary Manager. On 3/26/12 at 10:26 A.M., the following open liquids were observed without "preparation" or "use by" dates: 1/2 pitcher of "House shake," 1 full pitcher of tomato juice, and one full, opened bottle	F0371	Miller's Senior Living is requesting paper compliance with regards to the plan of correction submitted below. F 371 Food Procure, Store/Serve- Sanitary – Miller's Senior Living respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefix F371. 1.All residents that were served out of the Kitchen that particular day had the potential to be affected by the deficient practice. 1.Dates and labels were immediately placed on the unlabeled and undated items. 2.The Quaternary Solution was remixed to ensure the bucket contained the proper concentration of chemical. 3.The buckets were immediately placed in a designated area away from the food preparation area. 2.Again, All residents that were served out of the Kitchen that particular day had the potential to be affected by the deficient practice and the above mentioned corrections were completed immediately. 3.All dietary staff will be	04/22/2012

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	155271	A. BUILDING 00 B. WING	03/30/2012

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	of prune juice. At that time, in an interview, the Dietary Manager indicated staff usually date all open liquids, and the house shake and tomato juice were just prepared and placed in the pitchers. She indicated the prune juice carton was just opened by nursing staff and the nursing staff failed to date the carton. On 3/26/12 at 10:35 A.M., 3 trays of scooped vanilla ice cream were observed in the freezer without a date. At that time, in an interview with the Dietary Manager, she indicated dietary staff know to date all prepared food. On 3/26/12 at 10:40 A.M., 1 bucket of Quaternary [chemical disinfectant] was observed sitting on the shelf where food [celery and onions] were being prepared for the next meal. The concentration at that time was checked by the Dietary Manager with the facility testing strips. The concentration read 100 parts per million [ppm] [the correct concentration = 150 - 200 ppm]. At that time, in an interview, the Dietary Manager indicated staff should not place cleaning solutions near food preparation and staff mixed the concentration		educated on: 1. the importance of dating and labeling all open items. 2.The proper procedure for mixing the Quaternay Solution and proper procedure for testing the concentration of the chemical to ensure they are at an appropriate level. 3.Designated areas for placement of the Quaternay Solution buckets were identified. Staff were educated on these designated areas. 4.To ensure the deficient practice does not recur, an audit tool titled “State Survey Plan of Correction 2012 QA Tool” (Attachment C) will be completed by the Dietary Manager or designee 5 times per week for 2 weeks, weekly for 6 weeks and monthly thereafter. 5.The facility will have all inservicing completed and auditing in place by April 22, 2012.	

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	incorrectly. She indicated the correct concentration should be 200 ppm. 2. The Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24 Section 191. (a) included, but was not limited to, "refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed..." 3.1-21(i)(3)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to ensure the ice scoop was	F0441	Miller's Senior Living is requesting paper compliance with regards to the	04/22/2012

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	not stored inside of 1 ice chest, on 1 of 2 units. The deficient practice had the potential to affect 52 residents who resided on the second floor, of 66 residents currently residing in the facility who were provided ice. Findings include: On 3/27/12 at 2:00 P.M., the environmental tour was initiated with the Executive Director, Maintenance Director, Maintenance Assistant #1, and the Regional Housekeeping Manager. On 3/27/12 at 2:35 P.M., a portable ice chest cart was observed in the hallway on the second floor. The scoop used to obtain the ice from the chest was inside the container, and positioned on top of the ice. In an interview at that time, the Executive Director indicated nursing staff were not allowed to store the scoop in the ice chest. The scoop was removed from the ice chest, and both the scoop and ice chest were then removed from the floor by the Executive Director for cleaning. 3.1-18(b)(1)		plan of correction submitted below. F 441 Infection Control, Prevent and Spread – Miller's Senior Living respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefix F441. 1.To correct the deficient practice the ice scoop was immediately removed from the ice and the ice chest was removed from the floor to be cleaned. 2.All residents had the potential to be effected by the deficient practice. All ice chests were audited to ensure the scoop was not located in the ice chest and was properly placed to avoid infection control concerns. 3.Systemic changes were put in place by relocating the ice chest to be stored in a locked area. It will only removed from the locked area while it is being cleaned, filled, or while ice is being passed. This will ensure that no visitors have the potential to cause an infection control violation. All staff will be inserviced on this systemic change and the importance of proper storage of the ice scoop (as to not be located in the ice chest). 4.To ensure the deficient practice does not recur, an audit tool titled "Infection Control/ Ice Scoop" (Attachment D) will be completed by the DON or designee daily for 30 days, weekly for 4 weeks, monthly for 3 months. The QA team will review the audits at that time to determine if it is necessary to continue this QA tool. 5.The facility will have all inservicing completed and auditing in place by April 22, 2012.	

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